PATIENT Last Name	**First Name**	**M.I.**	DOB	Male or Female
Address	City	State	Zip	
Primary Phone#	Cell / Home / Other (circle one)			
Work/School	Occupation/Grade			
Email:	Referred by:			
Guardian/Spouse Name:	**Relationship to Patient:**	DOB	Phone	
Married/Single/Divorced/other				
Last **Eye Exam** Date:	Provider/Location:			
Last **Medical Exam** Date:	Provider/Location:			

List of Family members under the care of *281 Eyecare* Name/Relation

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Review of Systems

Are you currently experiencing, or have you experienced, any of the following? Check ALL that apply.

VISUAL	***MEDICAL HISTORY***			
☐ Blurred Vision Near or distance	**Const.**	☐ Develop Dis.	**GI**	☐ Crohn's
☐ Double Vision		☐ Cancer		☐ Colitis
☐ Flashes		☐ Fatigue		☐ Ulcer
☐ Floaters	**ENT**	☐ Hearing		☐ Acid Reflux
☐ Dryness		☐ Sinusitis		☐ Celiac Disease
☐ Irritation		☐ Dry Mouth	**Geni**	☐ Kidney disease
☐ Redness	**Neuro**	☐ Multiple Sclerosis		☐ Prostrate disease
☐ Itching/Burning		☐ Epilepsy		☐ STD
☐ Discharge		☐ Cerebral Palsy		☐ Pregnant
☐ Eye Pain/Soreness		☐ Stroke		☐ Nursing
☐ Headaches		☐ Migraine	**Musc**	☐ Osteoarthritis
☐ Poor Color Vision		☐ Autism		☐ Arthritis
☐ Light Sensitivity	**Psych**	☐ Depression		☐ Fibromyalgia
☐ Tired Eyes		☐ ADD		☐ Muscular Dystrophy
☐ Sand/Gritty Feeling		☐ Anxiety		☐ Ankylosing Spondylitis
☐ Halos/Glare		☐ Bipolar		☐ Osteoporosis
☐ Eye Strain	**Cardio**	☐ High blood pressure		☐ Gout
☐ Eye Turn		☐ Stroke	**Integ**	☐ Eczema
Other		☐ Heart Disease		☐ Rosacea
____________________		☐ Vascular		☐ Psoriasis
____________________		☐ Cong. Heart Failure		☐ Herpes/canker sores
____________________	**Resp**	☐ Smoker		☐ Herpes/Shingles
		☐ Asthma	**Endo**	☐ Type 2 Diabetes
☐ Currently wear glasses		☐ Bronchitis		☐ Type 1 Diabetes
☐ Currently wear contacts		☐ Emphysema		☐ Thyroid
		☐ COPD		☐ Hormonal Dysfunction
Reason for Today's Visit:		☐ Sleep Apnea	**Hemo**	☐ Anemia
				☐ Ulcer
				☐ High Cholesterol
			Allerg	☐ Drug allergies
				☐ Environmental
				☐ Rheumatoid arthritis
				☐ Lupus

Family History	None	Self	Father	Mother	Brother	Sister	Son	Daughter
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes 1	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes 2	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degen.	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐

Medications:

	For
	For
	For
	For
	For

Allergies (to medications and/or seasonal)

Alcohol use: Y N Amount:

Tobacco use: Y N Amount:

Are you currently **pregnant**? Y N Are you currently **nursing**? Y N

What do you use your eyewear for: (example: outdoors, reading, computer, etc.)

INSURANCE yes no		
Primary Ins. Company Name	ID No.	
Policy Holder	P.H. Employer	
Relation to policy holder	P.H. DOB	Vision or Medical (circle one)
Secondary Ins. Company Name	ID No.	
Policy Holder	P.H. Employer	
Relation to policy holder	P.H. DOB	Vision or Medical (circle one)

☐ I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me, or my child, during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

☐ I acknowledge that I had the opportunity to review and have received a copy if so desired of NOTICE of PRIVACY PRACTICES.

Signature ______________________ Date ______________